CHILD AND YOUTH SERVICES (CYS) HEALTH ASSESSMENT

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY:	Title 10, United States Code, Section 3013.
PRINCIPAL PURPOSE:	Information is used by DA personnel to: (1) verify child health status and currency of immunization per admission requirements; (2) note special program considerations or restrictions on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program.
ROUTINE USES:	Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.
DISCLOSURE:	Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CYS programs.

FAMILY INFORMATION *(Sponsor)*

NAME OF SPONSOR *(Last, First, MI)*	TELEPHONE *(Home)*	TELEPHONE *(Duty)*

NAME OF MEDICAL TREATMENT FACILITY/PHYSICIAN	ADDRESS *(Include ZIP Code)*	TELEPHONE

CHILD HEALTH INFORMATION *(Sponsor)*

NAME OF CHILD	BIRTH DATE	SEX

HAS CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN? *(If yes, explain circumstance(s) and current status)* ☐ YES ☐ NO

HAS CHILD BEEN SCREENED FOR ENROLLMENT IN EXCEPTIONAL FAMILY MEMBER PROGRAM? ☐ YES ☐ NO

IMMUNIZATION DATES *(List Month and Year)*

DPT 1: _____ 2: _____ 3: _____ 4: _____ 5: _____

TOPV 1: _____ 2: _____ 3: _____ 4: _____ 5: _____

HIB 1: _____ 2: _____ 3: _____ 4: _____

MMR 1: _____ 2: _____ Varicella: _____ TINE 1: _____ 2: _____

HEP A 1: _____ 2: _____ HEP B 1: _____ 2: _____ 3: _____

DISEASES AND ILLNESSES *(Check Yes, or No)*

CHICKEN POX: ☐ YES ☐ NO RUBELLA: ☐ YES ☐ NO TEN-DAY MEASLES: ☐ YES ☐ NO

MUMPS: ☐ YES ☐ NO POLIOMYELITIS: ☐ YES ☐ NO RHEUMATIC FEVER: ☐ YES ☐ NC

SCARLET FEVER: ☐ YES ☐ NO OTHER *(List)*: _____

CHRONIC ILLNESSES AND CONDITIONS *(Check yes, or No)*

VISION PROBLEMS: ☐ YES ☐ NO AUDITORY PROBLEMS: ☐ YES ☐ NO ASTHMA: ☐ YES ☐ NO

ORTHOPEDICS: ☐ YES ☐ NO SEIZURE DISORDER: ☐ YES ☐ NO DIABETES: ☐ YES ☐ NC

OTHER *(List)*: _____

ALLERGIES *(List)*: _____

COMMENTS/INDICATE FREQUENCY *(Circle Appropriate Answer)*

COLDS:	NEVER	SELDOM	OFTEN	UNKNOWN
EAR ACHES:	NEVER	SELDOM	OFTEN	UNKNOWN
STOMACH ACHES:	NEVER	SELDOM	OFTEN	UNKNOWN
HEADACHES:	NEVER	SELDOM	OFTEN	UNKNOWN

COMMENTS/INDICATE FREQUENCY *(Circle Appropriate Answer)*				
DIARRHEA:	NEVER	SELDOM	OFTEN	UNKNOWN
CONSTIPATION:	NEVER	SELDOM	OFTEN	UNKNOWN
BED WETTING:	NEVER	SELDOM	OFTEN	UNKNOWN
SLEEP DIFFICULTIES:	NEVER	SELDOM	OFTEN	UNKNOWN
POOR EATING HABITS:	NEVER	SELDOM	OFTEN	UNKNOWN
TANTRUMS:	NEVER	SELDOM	OFTEN	UNKNOWN
EXCESSIVE ACTIVITY:	NEVER	SELDOM	OFTEN	UNKNOWN

DESCRIPTION OF SERIOUS CHRONIC ILLNESS/CONDITIONS *(Medical Staff)*

ILLNESS/CONDITIONS	EARLY SYMPTONS	RECOMMENDED YS/SAS PROCEDURES

COMMENTS:

ON-GOING MEDICATION *(Medical Staff)*

TYPE	DOSAGE	FREQUENCY	YS/SAS ADMINISTERED

MEDICAL STAFF COMMENTS *(Medical Staff)*

HEIGHT: _____ WEIGHT: _____ VISION: _____ HEARING: _____

SPECIAL MEDICAL CONSIDERATIONS *(Medical Staff)*

DESCRIBE ANY SPECIAL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS WHICH THE CHILD REQUIRES, IN ORDER TO PARTICIPATE IN CYS PROGRAMS:

REFERRAL FOR CHILD FIND SCREENING: ☐ YES ☐ NO

MEDICAL STATEMENT *(Medical Staff)*

The above named child has been given a routine medical examination and has been found free of infectious or contagious diseases, and to be capable of participating fully in CYS programs with the exception listed above.

SIGNATURE OF MEDICAL FACILITY REPRESENTATIVE	DATE
SIGNATURE OF SPONSOR	DATE